EMPLOYEE / SPOUSE SIGN-OFF FORM (revised 6-2-08)

City of Green Bay

Wellness Incentive Requirements for PCP, HRA, and Physical/Health Activity

***Attention Employee / Spouse*: The requirements listed below are the basis for a significant financial incentive for City of Green Bay Employees. You must submit this form and the 'MD Alert Sign-Off Form' (if applicable) indicating that you completed all the requirements.**

Primary Care Physician (PCP) Requirement:

I certify that I am registered as a patient with a Primary Care Physician (PCP), i.e., Obstetrician/ Gynecologist, Internist, Family Practitioner, General Practitioner, etc.
Name of PCP (Please Print): ____

Health Risk Assessment (HRA) Requirement:

Employee / Spouse must participate in the confidential health risk assessment (HRA) screening and review. There is no cost to employee / spouse.

SPOUSES: _____ *Check here if you participated this year in an HRA at your employer. If so, the spousal HRA requirement is waived for the City of Green Bay Wellness Incentive Program.*
Spouse's employer: ____

Physical Or Other Health Related Activity Requirement:

Complete any **one** of the following Physical or other Health Related Activities, *or any other similar activity as deemed appropriate by you (employee / spouse)* to meet this requirement.
****** Please check the activity you completed or fill in the "Other" section. ******

Examples (check all that apply):

_____ Participation in any "Fun Run / Walk" activity
_____ Participation in education / training / learning such as "Lunch and Learn" sessions
_____ Participation in the level of "Active" Disease Management
_____ Self reported activity time at a local Fitness Club or YMCA
_____ Individual physical activities, such as walking program, softball league participation, etc.
_____ Participation in a Smoking Cessation Program; Weight Management classes or groups; Stress Management classes; etc. Class: ______________________________
_____ Job oriented 'targeted training'. Training: ______________________________
_____ Any other physical or other health related activity as deemed appropriate by you: ____
_____ Other: ____

I certify that I have completed the above requirements in _________ (fill in current year).

**** Person completing this form: ___EMPLOYEE ___SPOUSE (write employee name below) ****

Employee Name (Print): ______________________________ Dept.____________________

Spouse Name (Print): ____

Signed: ____ Date: ____________________

Please return signed form to Human Resources, Attn: Laurie Maroszek when requirements are completed, but no later than November 15th

White: City of GB Human Resources Yellow: Employee / Spouse